

**DEPARTMENT OF LABOR AND INDUSTRIES  
CLAIMS SECTION  
PO BOX 44291  
OLYMPIA WA 98504-4291**

**Note: Please fold in thirds using mark along the left edge so the address will show in a window envelope.**

If you have changed doctors, you must notify and obtain authorization from your claims manager. We are sending you this card to request a change of doctor. Please fill out and return this card as soon as possible to ensure your medical services are not interrupted.

To:  
Department of Labor and Industries

Claim No.

Date I changed physicians

**Please transfer my medical case**

Name of doctor

**From:**

Name of doctor

**To:**

Provider ID#

Address of new doctor

City

State

ZIP

Reason for transfer

Today's date

Claimant's name

Address

City

State

ZIP

Claimant's signature